STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 01 B. WING	09/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNSHIRE HEALTH CARE CENTER	8380 VIRGINIA ST MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/19/11 Facility Number: 000577 Provider Number: 155650 AIM Number: 100266950 Surveyor: Richard D. Schade, Life Safety Code Specialist At this Life Safety Code survey, Lincolnshire Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The 1984 building was surveyed with Chapter 19, Existing	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Health Care Occupancies This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The original building was constructed in 1984. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 100 and had a census of 79 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/23/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0017 SS=E	Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 1 reception offices was separated from the corridor by a partition capable of resisting the passage of smoke, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by	K0017	K 017 The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care. Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. To ensure compliance, the facility will have an electrically supervised automatic smoke detector installed in the reception office area. A bid will be obtained for the installation by 10/19/11 and a plan in place for installation following receipt of the bid. Maintenance will audit all corridors to ensure compliance to Life Safety Code. Monitoring will be through the Monthly Audits on the TELS Program. Administrator will make a monthly review of the TELS Program to ensure facility	10/19/2011

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	automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect all residents evacuated through the main entrance in the event of an emergency. Findings include: Based on an observation with the maintenance supervisor on 09/19/11 at 10:25 a.m., the reception office at the main entrance had a double sliding glass window to the corridor. There was a one fourth inch gap between the two window panes. Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met in that the office area was not protected by an electrically supervised automatic smoke detection system. This was acknowledged by the maintenance supervisor at the time of observation. 3.1-19(b)		is staying compliant. Environmental Consultants will review TELS and monitor the facility for compliance during routine visits.	

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K0027 SS=E	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. This deficient practice could affect all residents, staff and visitors on the A wing of the B hall. Findings include: Based on observation with the maintenance supervisor at 1:20 p.m. on 09/19/11, the set of smoke barrier doors from A wing to B Hall had four 1/4 inch screw holes through the door which would allow the passage of smoke. The maintenance supervisor stated at	K0027	K 027 The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care. Door openings in smoke barriers have at least a 20-minute fire protection rating…. Maintenance staff will ensure compliance by sealing holes in the barrier doors. Fire Rated seal will be provided to make the repair. Maintenance Supervisor will complete a review of all Fire and Smoke Rated Barrier door sets throughout the facility to ensure protection from the passage of smoke. This will be completed by 10/19/11. Maintenance Supervisor will make Monthly Facility Audits on TELS Program to ensure all corridors are properly sealed to protect the passage of smoke. Administrator will make a monthly	10/19/2011

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	the time of observation, he was not aware of the problem. 3.1-19(b)		review of the TELS Program to ensure audits are being completed. Environmental Consultants will review TELS Program and monitor the facility for compliance during routine visits.	
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 2 of 11 hazardous room doors would close and latch automatically to prevent the passage of smoke. This deficient practice could affect residents, visitors and staff in and near the central supply storage room and mechanical room #3. Findings include:	K0029	K 029 The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care. Hazardous Areas are separated from other areas of the facility by doors with self-closing devices. Maintenance will ensure the Central Supply and Mechanical Room #3 has self-closing devices and ensure each door closes and latches into frame. This will be completed by	10/19/2011

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	Based on observation with the maintenance supervisor on 09/19/11 at 12:40 p.m., the doors to the 10 by 10 foot central supply storage room containing cleaning supplies, equipment and boxes; and mechanical room # 3 which contained heating and cooling equipment did not have door closers and did not automatically close and latch. The maintenance supervisor acknowledged the problem areas at the time of observation. 3.1-19(b)		10/19/11. Maintenance Supervisor will make a review of all Hazardous Room areas to ensure each has self-closing devices and each door closes automatically and latch. This review will be completed by 10/19/2011. Maintenance Supervisor will complete Monthly Preventative Maintenance Audits on TELS to ensure compliance. Administrator will make a monthly review of TELS Program to ensure audits are being completed on time. Environmental Consultants will make a review of TELS Program and monitor facility compliance during routine visits.	
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure exit egress for 1 of 10 exits was arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1	K0038	K 038 The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care. Exits are	10/19/2011

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	requires the means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.2 through 7.1.6.4. LSC Section 7.1.6.2 requires abrupt changes in elevation shall not exceed 1/4 inch. LSC Section 7.1.6.3 requires walking surfaces to be nominally level. LSC Section 7.1.6.4 requires walking surfaces to be slip resistant under foreseeable conditions. This deficient practice could affect any residents, staff and visitors using the A wing, B hall exit. Findings include: Based on observation with the maintenance supervisor on 09/19/11 at 2:00 p.m., the concrete surface outside the facility's A wing, B hall exit had a crack one inch in width with a depth of at least one inch. The maintenance supervisor stated at the time of observation, he was aware of the		arranged to be readily accessible at all times. Maintenance will obtain bids from an outside contractor and work will be scheduled by 10/19/11 to have repairs made to the concrete surface to prevent a trip hazard. Maintenance will complete an inspection of all exit egress walkways to ensure protection from trip hazards. This inspection will be completed by 10/19/11. Maintenance will perform Monthly Facility Audits on TELS Program to ensure continued compliance. Administrator will make a monthly review of TELS to ensure compliance. Environmental Consultants will review TELS and monitor compliance during routine visits.	

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	problem. 3.1-19(b)			
K0046 SS=F	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generator room battery backup lights was tested annually for a 90 minute duration to ensure the light would provide lighting during periods of power outages to protect 100 of 100 residents. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and	K0046	K 046 The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care. Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. Monthly TELS task for Maintenance requires the routine testing for 30 seconds along with an Annual test for 90-minute duration. The generator battery backup lighting was installed, at this facility, in the Spring Season of this year 2011, therefore, there would be no documentation for the Annual Test at the time of this survey. Maintenance will complete the Monthly and Annual TELS task of	10/19/2011

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	tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of the Preventive Maintenance Log with the maintenance supervisor on 09/19/11 at 11:20 a.m., it was documented the emergency generator room battery backup light was tested monthly but there was no documentation of an annual ninety minute test. The maintenance supervisor stated at the time of record review, the emergency generator battery backup light was not tested annually for a ninety minute duration. 3.1-19(b)		testing the emergency backup lighting as scheduled. Administrator will make a monthly review of the TELS audits ensure continued compliance. Environmental Consultants will make a review of TELS Program and monitor facility compliance during routine visits.	

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K0051 SS=F	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff. Findings include: Based on observation with the maintenance supervisor on 9/19/11 at 3:10	K0051	K 051 The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care. A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code. Maintenance will ensure circuit breaker for Fire Alarm Panel is marked in red and labeled as required. This will be completed by 10/19/11. Maintenance Supervisor will ensure routine audits are completed in a timely matter on TELS Program. Administrator will	10/19/2011

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	p.m., the fire alarm system circuit breaker located in the emergency power breaker box lacked identification. The maintenance supervisor stated at the time of observation, he was not aware the fire alarm circuit breaker was to be identified.. 3.1-19(b)		make a monthly review of the TELS Program to ensure audits are being completed timely. Environmental Consultants will review TELS and monitor facility compliance during routine visits.	
K0064 SS=E	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the kitchen was readily identified as a secondary backup to the automatic fire suppression system. NFPA 10, 1998 Edition, 2-3.2.1 requires fire extinguishers to include a conspicuously placed placard which states the automatic fire protection system is to be activated before using the fire extinguisher. This deficient practice affects all staff in and near the kitchen. Findings include:	K0064	K 064 The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care. Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. Maintenance will ensure fire extinguisher in dietary is properly identified as secondary backup to suppression system. Placard shall state: "Automatic fire protection system is to be activated before using fire extinguisher". This placard will be installed by 10/19/11. Maintenance will ensure compliance through completion of routine Monthly audits on TELS Program. Administrator will make	10/19/2011

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	Based on observation with the maintenance supervisor on 09/19/11 at 2:35 p.m., a placard was not placed near the Class K extinguisher in the kitchen. The maintenance supervisor stated at the time of observation, he was not aware of the requirement. 3.1-19(b)		a monthly review of the TELS Program to ensure compliance. Environmental Consultants will review TELS Program and monitor compliance during routine visits.	
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/19/11 Facility Number: 000577 Provider Number: 155650 AIM Number: 100266950 Surveyor: Richard D. Schade, Life	K0000		

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	Safety Code Specialist At this Life Safety Code survey, Lincolnshire Health Care Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The Therapy Room was added to the original 1984 building in 2009 and was surveyed with Chapter 18, New Health Care Occupancies This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The Therapy Room was constructed in 2009. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 100 and had a census of 79 at the time of this survey.			

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